BENOE
EYE & OCULOPLASTIC SURGEONS

CONSULTATION REQUEST FORM

All referrals are reviewed within 2-3 business days. A notification of the patient's appointment will be provided via fax. Form can be **Faxed:** 905-785-8384 OR **emailed:** referral@beos.ca

REFERRING DR.		BILLING NUMBER			
ADDRESS			EMAIL		
OFFICE PHONE		OFFICE FAX			

PATIENT DEMOGRAPHICS

PATIENT FIRST NAME			PATIENT LAST NAME		
PATIENT ADDRESS				CITY	
PATIENT EMAIL				POSTAL CODE	
HOME PHONE				CELL PHONE	
HEALTH CARD #		VC		DOB (MMDDYY)	

CLINICAL ASSESSMENT

BCVA	**OD**		**REFRACTION**	**OD**	
	OS			**OS**	
IOP	**OD**		**OTHER FINDINGS**		
	OS				

REASON FOR REFERRAL

CATARACT	☐	STANDARD IOL	☐	ADVANCED IOL	☐	REFRACTIVE LENS EXCHANGE	☐	PCO
ANT SEGMENT	☐	PTERYGIUM	☐	DRY EYE	☐	KERATITIS	☐	CORNEA
GLAUCOMA	☐	HIGH IOP	☐	FIELD LOSS	☐	DISC CUPPING	☐	NARROW ANGLES
OCULOPLASTICS	☐	BLEPHAROPLASTY	☐	EYELID DISORDER	☐	EYELID LESION	☐	TEARING
RETINA	☐	DIABETES	☐	ARMD / ANTI-VEGF	☐	RETINAL TEAR	☐	PLAQUENIL CHECK
NOTES / OTHER								

Has the patient seen an ophthalmologist in the past? Yes ☐ (*please include all relevant details and past reports*) No ☐

Please indicate any accessibility needs of the patient that may require accommodation:

Location Preference: ☐ FIRST AVAILABLE or specify: _____